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State Illinois

9. Community Mental Health Services

Mental Health Services are to be provided to eligible recipients who require such services:

1. to effectively manage current symptoms of mental illness through treatment or rehabilitation programs;

2. to promote growth or maintenance of independent functioning following episodes of institutionalization;

3. to prevent deterioration in independent role functioning which may result in inpatient treatment; or

4. to relieve personal distress and stabilize functioning following crises which may reduce the clients ability to function independently.

All services will be provided by or under the direct supervision of a Qualified Mental Health Professional. The QMHP may be a registered psychologist; a registered, certified social worker; a licensed RN; a registered occupational therapist; or an individual who holds a masters degree or higher in psychology, sociology, or counseling and who is certified or registered by a recognized national or State certification board or commission. In addition, all Qualified Mental Health Professionals must have a minimum of one year of relevant work experience.

All services must be provided in a community setting which is certified by the Illinois Department of Mental Health and Developmental Disabilities. Clinics which are not certified are not eligible to provide services under this provision of the State Plan.

All services under this section of the Plan must be provided under the direction of a fully licensed physician. The physician must review and approve the treatment plan whenever significant changes in the plan occur, or at least once every six months for adult recipients and at least every three months for children and adolescents.

Community Mental Health Services will include only the following services:

- Assessment - Assessments will be provided to determine the condition of the recipient and the nature and extent of services required. Mental Health assessments, Psychiatric assessments, and Psychological assessments may be provided to obtain information on the nature and extent of presenting problems and the present level of functioning of clients.

- Treatment Plan Development and Modification - An individual treatment plan must be provided within 30 days of the initiation of service for all clients served under this section. The individual treatment plan must state the overall goals of treatment and shall indicate the specific mental health services to be provided. The plan must be developed or approved by a physician, and must be reviewed and modified as necessary, but at least every six months for adults and three months for children.

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OFFICIAL

State Illinois

- Psychotropic Medication Monitoring and Training - Monitoring of Psychotropic medications and training of clients in self medication may be provided by RNs as part of community mental health services. The monitoring will include recording of medications prescribed and taken by the client; observation of the effectiveness of medication; observation of any side effects resulting from the medication; and assurance that medication is being used in accordance with the prescription and in accordance with sound medical practice. Training shall be provided to clients by RNs to promote self medication, and will include training on side effects and adverse reactions; proper dosage; proper timing of medication; storing and safeguarding medication; and communication with mental health professionals regarding medication issues.

- Crisis Intervention - Crisis intervention shall be provided to clients who are experiencing a psychiatric crisis. The service is intended to reduce symptomology, stabilize and restore the client to a previous level of role functioning and to assist the client in functioning in the community. Services include immediate mental health assessment; brief and immediate therapy; and referral or linkage to appropriate mental health services.

- Psychiatric Therapy - Psychiatric and psychological therapy will be provided to clients who require interpersonal therapy to promote growth in role functioning in order to maintain the client's functioning in the community. Services available include individual therapy, group therapy, and family therapy.

- Day Treatment - Day treatment shall include services provided on an integrated, comprehensive schedule of recognized psychiatric treatment addressing at least three areas of dysfunction: psychological, interpersonal and primary role dysfunction. Services will include: (1) intensive stabilization, provided in a structured environment, to resolve short term problems or crises which could lead to institutionalization; and (2) extended treatment services focused on the development of interpersonal and living skills to restore client functioning and facilitate reentry into the family and community. Both services will include elements of therapy, skills development and training, and assessment and treatment planning.

- Case Management - Case management services will be provided to assist clients in gaining access to mental health services and to collateral services which will compliment mental health services. The case manager will also assure the appropriateness of mental health services provided, and will review the results of treatment to assure that services are effective.

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OFFICIAL

State Illinois

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES — OTHER TYPE OF CARE - BASIS FOR REIMBURSEMENT

16. APPLIANCES/PROSTHESES: Most reasonable cost for the item which will adequately meet the client's needs. Most reasonable cost is based on the lowest of two or three estimates given prior to purchase.

17. MEDICAL SUPPLIES AND EQUIPMENT: Medical Supplies - Reimbursed at Department's maximum rate (cost plus 50%). Medical Equipment - Lowest price available in the geographic area where the client resides.

18. TRANSPORTATION: Lesser of charges or Department maximum. Ambulance, medicar and service car provides: base rate plus mileage rate; oxygen add-ons may be reimbursed when provided in ambulance or medicars. Commercial carrier transportation is approved on case-by-case basis and reimbursed at the prevailing or a negotiated rate.

19. FAMILY PLANNING: Variable maximum per visit category: initial visit, annual visit, routine visit, problem visit and supply visit.

20. MEDICHEK SERVICES: (Early and Periodic Screening and Diagnosis): Variable maximum depending upon provider type: hospital outpatient clinic facility - Department approved outpatient rate; encounter rate clinic - Department approved visit rate; physician visit - Department approved rate(s).

21. DIAGNOSTIC, PREVENTIVE AND REHABILITATIVE SERVICES: Depending on the circumstances under which it is rendered, any of the above services could fall into the classification of diagnostic, preventive or rehabilitative. Reimbursement provided for such services is made in the same manner as described for Items 1 through 19.

22. COMMUNITY MENTAL HEALTH SERVICES: The amount approved for payment for mental health clinic services shall be based on the type and amount of service required by and actually delivered to a client. The amount is determined in accordance with the prospective rates developed by the Department of Mental Health and Developmental Disabilities and as adopted by the Department of Public Aid for Medicaid reimbursable services. The adopted rate shall not exceed the charges to the general public.

A statewide rate shall be established annually for each category of service. New statewide rates shall reconcile the prior years rate to actual cost and include an update for inflation. Services will be reimbursed on the basis of hourly cost, prorated to the appropriate units of time for each service. Units of service are indicated below.

1) Complete assessment - three hours
2) Treatment Plan Development and Modification - quarter hour
3) Medication Monitoring and Training - quarter hour
4) Crisis Intervention - quarter hour
5) Day Treatment - hourly
6) Case Management - hourly
7) Psychiatric and Psychological Therapy - quarter hour

Rates for group and family therapy will assume multiple clients per session, and will distribute the hourly staff costs across the multiple participants.

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Pen and ink correction made per telephone conversation with T Tokelman on 6/6/88 B J England

State Illinois

OFFICIAL

HOSPICE SERVICE

Hospice care is a covered service for all eligible clients, including residents of intermediate and skilled care facilities, when provided by a Medicare certified hospice provider and in accordance with provisions contained in 42 CFR 418.1 through 418.405.

An add-on payment will be made for those clients residing in ICF or SNF facilities to cover room and board charges payable by the hospice provider.

Medicaid payment to a hospice provider for care furnished over the period of a year shall be limited by a payment cap as set forth in 42 CFR 418.309.

Covered services under the Hospice Program include:

- nursing care
- physician services
- medical social services
- short term inpatient care
- medical appliances, supplies and drugs
- home health aide services, and
- therapy and speech-language pathology services to control symptoms.

There are four levels of care into which each day of care is classified:

Routine Home Care. The hospice will be paid the routine home care rate for each day the patient is at home, under the care of the hospice, and not receiving continuous home care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day.

Continuous Home Care. The hospice will be paid the continuous home care rate when continuous home care is provided. The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate. A minimum of eight (8) hours must be provided. For every hour or part of an hour of continuous care furnished, the hourly rate will be reimbursed to the hospice up to 24 hours a day.

Inpatient Respite Care. The hospice will be paid at the inpatient rate for each day on which the beneficiary is in an approved inpatient facility and is receiving respite care. Payment for respite care may be made for a maximum of five (5) days at a time, including the date of admission, but not counting the date of discharge. Payment for the sixth day and any subsequent days is to be made at the routine home care rate.

General Inpatient Care. Payment at the inpatient rate will be made when general inpatient care is provided. None of the other fixed payment rates (i.e., routine home care) will be applicable for a day on which the patient receives hospice inpatient care except for the day of discharge from an inpatient unit. In which case, the appropriate home care rate is to be paid unless the patient dies as an inpatient.

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State: Illinois

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

MEDICALLY NEEDY GROUP: MEDICALLY NEEDY INDIVIDUALS WHO ARE AFDC-RELATED AND WHO ARE AGE 18 OR OVER AND NOT PREGNANT

The following ambulatory services are provided.

- Hospital emergency room visits
- Clinic, including Rural health
- Physician
- Home Health Agencies
- Medical equipment and supplies (durable and non-durable)
- Eyeglasses, prosthetic devices
- Laboratory and x-ray, including Cat Scans
- Transportation
- Family planning services
- Optometrist services and supplies
- EPSDT

In addition, hospital outpatient services, dental services and prescribed drugs are provided.

83-25 Page 1 revised pg. 12/23/83

Date

OFFICIAL

State: Illinois

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

MEDICALLY NEEDY GROUP: MEDICALLY NEEDY INDIVIDUALS WHO ARE AFDC-RELATED AND WHO ARE AGE 18 OR OVER AND NOT PREGNANT

1.	Inpatient hospital services other than those provided in an institution for mental diseases or tuberculosis	/X/	Provided
		/ /	No limitations
		/X/	With limitations*
2.a.	Ouptatient hosptial services	/X/	Provided
		/ /	No limitations
		/X/	With limitations*
2.b.	Rural health clinic services and other ambulatory services furnished by a rural health clinic	/X/	Provided
		/ /	No limitations
		/X/	With limitations*
3.	Other laboratry and X-ray services	/X/	Provided
		/ /	No limitations
		/X/	With limitations*
4.a.	Skilled nursing facility services (other than services in an institution for tuberculosis or mental diseases) for individuals 21 years of age or older	/X/	Provided
		/X/	No limitations
		/ /	With limitations*

83-25 Dated 12/23/83
revised pg.

*Description provided on attachment.

☐
_____ Date_____

State: Illinois

OFFICIAL

OUTPATIENT HOSPITAL SERVICES

1. Outpatient hospital services are covered for surgical procedures and related ancillary services, renal dialysis, outpatient follow-up of second and third degree burn treatment provided by the hospital burn unit, and cancer treatment, including chemotherapy, radiation therapy and ancillary services.

2. Physician, lab and x-ray, and cat scans are covered in any setting. (EXCEPTION: A total body scan is only provided in an inpatient hospital setting.)

3. Emergency treatment in the hospital emergency room is unlimited for true emergency diagnosis, care and treatment.

83-25 Revised pg. 12/23/83

Date

OFFICIAL

State: Illinois

3. Other laboratory and x-ray services. Full mouth series of x-rays are covered only once every three years.

Total body scans only when provided in an inpatient hospital setting. No separate payment is made for the scan (included in hospital per diem). Physician fee for interpretation is paid.

83-25 Revised pg. 12/23/83

Date

State: Illinois

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

MEDICALLY NEEDY GROUP: MEDICALLY NEEDY INDIVIDUALS WHO ARE AFDC-RELATED AND WHO ARE AGE 18 OR OVER AND NOT PREGNANT

4.b. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found

- /X/ Provided
  - /X/ No limitations
  - /_/ With limitations* (in accordance with federal requirements)

4.c. Family planning services and supplies for individuals of child-bearing age

- /X/ Provided
  - /X/ No limitations
  - /_/ With limitations*

5. Physicians' services whether furnished in the office, the patient's home, a hosptial, a skilled nursing facility or elsewhere

- /X/ Provided
  - /_/ No limitations
  - /X/ With limitations*

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law

a. Podiatrists' Services

- /_/ Provided
  - /_/ No limitations
  - /_/ With limitations*

83-25 Dated 12/23/83
revised pg.

*Description provided on attachment.

_____ Date_____

TN # 83-25
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OFFICIAL

State: Illinois

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

MEDICALLY NEEDY GROUP: MEDICALLY NEEDY INDIVIDUALS WHO ARE AFDC-RELATED AND WHO ARE AGE 18 OR OVER AND NOT PREGNANT

b. Optomertrists' Services
- [X] Provided
- [ ] No limitations
- [X] With limitations*

c. Chiropracters' Services
- [ ] Provided
- [ ] No limitations
- [ ] With limitations*

d. Other Practitioners' Services
- [ ] Provided
- [ ] No limitations
- [ ] With limitations*

7. Home Health Services

a. Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area
- [X] Provided
- [ ] No limitations
- [X] With limitations*

b. Home health aide services provided by a home health agency
- [X] Provided
- [ ] No limitations
- [X] With limitations*

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☐ Disapproved ☐ Withdrawn
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*Description provided on attachment.

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